12.a. Prescribed Drugs

A. Provided with limitations.

Prior authorization by the Medicaid agency is not required for legend drugs. The following are not covered: anorectics or any agent used to promote weight loss; topical minoxidil preparations; fertility enhancement drugs; drugs prescribed solely or primarily for cosmetic purposes.

B. In accordance with Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990), Indiana Medicaid will fully participate in the manufacturer rebate program. In doing so, all applicable provisions and restrictions of the legislation, as well as that of any subsequent rules and/or regulations, will be strictly adhered to. Specifically, Indiana Medicaid will reimburse for all rebating manufacturers' (as identified to the agency by HCFA) products fully in accordance with the specifications of the legislation. The program will also adhere to all reporting requirements of the legislation.

C. Services provided to recipients in long-term care facilities:

1. Prior authorization by the Medicaid agency is not required for legend pharmaceuticals provided to recipients living in long-term care facilities. The following are not covered: anorectics or any agent used to promote weight loss; topical monoxidil preparations; fertility enhancement drugs; drugs prescribed solely or primarily for cosmetic purposes.

2. The limitations set out in 405 IAC 5-24-6 apply to fees charged for the dispensing of legend drugs when such drugs are provided to recipients residing in Medicaid certified long term care facilities.

12.a. Prescribed drugs	C.3. Non-legend drugs included on the Medicaid non-legend drug formulary are covered subject to the limitations set out in 405 IAC 5-24-1, et seq. D. Services provided to recipients not in hospitals or long term care facilities: 1. Prior authorization by the Agency is not required for legend drugs. The following are not covered: anorectics or any agent used to promote weight loss; topical minoxidil preparations; fertility enhancement drugs; drugs prescribed solely or primarily for cosmetic purposes. 2. All over-the-counter and non-legend items are subject to the limitations set out in 405 IAC 5-24-1, et seq.
12.b. Dentures	Not provided. Through 1/31/96, Medicaid will continue to reimburse for services prior authorized before 8/1/95, provided the prior authorization is valid for the date of service and the service is furnished on or before 1/31/96.*

*In accordance with the opinion of the Court of Appeals of Indiana in Coleman v. Indiana Family and Social Services Administration and Thie v. Davis, et al., Medicaid coverage of dentures, subject to Prior Authorization, is reinstated, effective 4/23/98 and coverage of partial dentures is reinstated effective 10/30/97. PA is subject to criteria in 405 IAC 1-6 and 1-7 that were in effect prior to 8/1/95.

12.c. Prosthetic devices	Provided with limitations. Prior review and authorization by the agency is required for all prosthetic devices as set out in 405 IAC 5-24-1, et seq.
12.d. Eyeglasses	Provided with limitations. For an individual to receive an initial or subsequent pair of glasses there must be a minimum initial prescription or change in one eye of .75 diopters for patients ages 6 to 42 and .50 diopters for patients over age 42, or an axis change of at least 15 degrees.
13. Other diagnostic, screening, preventive, & rehabilitative services	Provided with limitations.
13.a. Diagnostic services	Diagnostic services are provided within the limitations placed on the applicable categories of service, as set out in 405 IAC 5.
13.b. Screening services	Screening services are provided within the limitations placed on the applicable categories of service, as set out in 405 IAC 5.

13.c. Preventive services — Preventive services are provided within the limitations placed on the applicable categories of service, as set out in 405 IAC 1-6 and 1-7.

13.d. Rehabilitative services — All rehabilitative services require prior authorization by the agency, except those ordered in writing by a physician prior to the patient's discharge from a hospital. All services must be medically necessary. Educational services are not covered. All therapies provided in a rehabilitation center must be provided in accordance with 405 IAC 1-6-20.

13.d.(1) Community Mental Health Rehabilitation services — Provided with Limitations
Medicaid reimbursement is available for community mental health rehabilitation services subject to the following:

(a) Covered rehabilitation services are defined as:

(1) Outpatient mental health services. Outpatient mental health services are mental health clinical services that are provided to individuals, families, or groups of persons who are living in the community and who need aid on an intermittent basis for emotional disturbances of mental illness including but not limited to, diagnostic assessment, pre-hospitalization screening, individual counseling/psychotherapy, conjoint counseling/psychotherapy, family counseling/psychotherapy, group counseling/psychotherapy, crisis intervention, medication/somatic treatment, and training in activities of daily living; components of this service include:

(A) clinical attention in the recipient's home, work place, mental health facility, emergency room or wherever urgently needed; and

(B) may include the emergency provision of chemotherapy, first aid or other medical care.

(2) Partial Hospitalization services. Partial Hospitalization services refers to a group activity program provided two or more hours per day for individuals who need less than full-time hospitalization but more extensive and structured treatment than on an intermittent, hourly basis, and provided in the following manner:

(A) provided on part-days, evenings or weekends; and

(B) provided by a clinical team.

(3) Case Management services. Refers to those services described in Supplement 1 to Attachment 3.1-A, pages 7-10.

(b) Limitations:

(1) Medicaid will reimburse for community mental health rehabilitative services when:

(A) provided to a person requiring mental health services;

(B) provided by personnel who meet appropriate federal, state and local regulations for their respective discipline or are under the supervision/direction of a qualified mental health professional; and

(C) provided through a mental health center which meets applicable federal, state, and local laws concerning the operation of community mental health centers including but not limited to licensure, certification, organization, staffing, service provision, maintenance of health records, quality assurance and program evaluation;

(D) provided by mental health providers approved by the Department of Mental Health under IC 16-16-1-1 and in accordance with 440 IAC 4-1 through 4-6.

(2) The supervising physician bears the ultimate responsibility for certifying the diagnosis and plan of treatment. The physician is responsible for seeing the patient during the intake process or reviewing information obtained by the Qualified Mental Health Professionals, and approving the initial treatment plan. The physician must see the patient or review the treatment plan submitted by the Qualified Mental health Professionals at intervals not to exceed 90 days. The physician must be available to see patients when emergencies arise and when requests are made for additional consultations.

c) A qualified mental health professional is defined as:

* a licensed psychiatrist
* a licensed physician
* a licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
* an individual who has had at least two years of clinical experience with persons with mental illness under the supervision of a mental health professional, such experience occurring after the completion of a master's or doctoral degree, or both, and who possesses one of the following sets of credentials:
  * a master's or doctoral degree, or both, in psychiatric nursing from an accredited university plus a license as a registered nurse in Indiana; or
  * a master's or doctoral degree, or both, in social work from a university accredited by the Council on Social Work Education;
  * a master's degree or doctoral degree, or both in psychology from an accredited university, and who meets the Indiana requirements for the practice of psychology;
  * a master's degree or doctoral degree, or both, in counseling and guidance from an accredited university;

* a master's degree or doctoral degree, or both, in pastoral counseling from an accredited university;
* a master's degree or doctoral degree, or both, in rehabilitation counseling from an accredited university; or
* a mental health professional who has documented equivalence in education, training and/or experience approved by the supervising physician.

14. Services for individuals age 65 or older in institutions for mental diseases	Provided with limitations.
14.a. Inpatient hospital services	Medicaid reimbursement is available for medically necessary services in an inpatient psychiatric facility only when the recipient's need for admission has been certified in accordance with the applicable requirements set out in 405 IAC 1-7-20. Medicaid reimbursement is available for emergency admissions only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of a bodily organ or part; the death of the individual; or, serious harm to another person by the individual.

15 a. Intermediate Care Facility Services	Provided with limitations. Prior review and authorization by the Medicaid agency is required for nursing home admissions, level of care and scope of services for recipients admitted to a long term care facility. All services listed undr skilled nursing facility services and previously discussed in this attachment as requiring prior review and authorization (ancillary services) will also require prior review in an intermediate care facility.
15.b. ICF/MR Services	Provided with limitations. Preadmission diagnosis and evaluation is required for placements in ICF's/MR in addition to approval of the placement by the Medicaid agency. ICF/MR services are available in appropriately certified public and private institutions. Medicaid reimbursement is available for day services provided in a Family and Social Services Administration approved setting when such services are required by the resident's program plan of active treatment developed in accordance with 42 CFR 483.440
16. Inpatient Psychiatric Facility Services for Individuals under 21	Provided with limitations. Prior review and authorization by the Medicaid agency is required for inpatient psychiatric facility services for individuals under 21.
17. Nurse-Midwife Services	Provided with limitations. Prior review and authorization by the Medicaid agency is required for all nurse midwife services.

18. Hospice Care

Provided with limitations.

Medicaid reimbursement is available for hospice services subject to the requirements set out in 405 IAC 1-16 and the limitations in Indiana Medicaid's covered services rule at 405 IAC 5. Hospice services consist of palliative care for the physical, psychological, social, spiritual and other special needs of a hospice program patient during the final stages of the patient's terminal illness; and care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death. Bereavement counseling is a non-covered service.

Hospice services require prior approval by the Medicaid agency or its contractor. Hospice eligibility is available in the following consecutive benefit periods: (1) One period of 90 days.(2) A second period of 90 days.(3) An unlimited number of periods of 60 days.

Approval must be granted separately for each benefit period. If benefit periods beyond the first 90 days are necessary, then re-certification on the physician certification form and an updated plan of care are required for prior approval of the second and subsequent benefit periods.

When approval for a benefit period has been granted, a hospice provider may manage a patient's care at the four levels of care according to the medical needs determined by the interdisciplinary team and the requirements of the patient and the patient's family or primary care-givers. Changes in levels of care do not require prior approval as long as these levels are rendered within a prior approved hospice benefit period.

The hospice provider must utilize an interdisciplinary team. At a minimum, the group must include all of the following persons: (1) A Medical Director, who must be a doctor of medicine or osteopathy; (2) A registered nurse;(3) A social worker;(4) A pastoral or other counselor.

In order for an individual to receive Medicaid-covered hospice services, a physician must certify that the individual is terminally ill and expected to die from that illness within six months. In order to receive hospice services, a recipient must elect hospice services by filing an election statement with the hospice provider on forms specified by the Medicaid agency. When an eligible recipient elects to receive services from a certified hospice provider, the provider shall develop a plan of care. The certification, election statement and plan of care must be prepared in accordance with the criteria set out in 405 IAC 5.

18. Hospice Care (continued)

Services covered within the hospice per diem reimbursement rates include:

(1) Nursing care provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker who has at least a bachelor's degree and who is working under the supervision of a physician.

(3) Physicians' services provided by the medical director or physician member of the interdisciplinary team which may be characterized as follows:

(a) general supervisory services;
(b) participation in the establishment of the plan of care;
(c) supervision of the plan of care:
(d) periodic review; and
(e) establishment of governing policies.

(4) Counselling services provided to the recipient and the recipient's family or other person caring for the recipient.

(5) Short-term inpatient care provided in a hospice inpatient unit, participating hospital or nursing home, subject to the limits in 405 IAC 1-16-3.

(6) Medical appliances and supplies, including palliative drugs, which are related to the palliation or management of the recipient's terminal illness.

(7) Home health services furnished by qualified aides.

(8) Homemaker services which assist in providing a safe and healthy environment.

(9) Physical, occupational therapy and speech-language pathology services provided for purposes of symptom control.

(10) Any other item or service specified in the recipient's plan of care, if the item or service is a covered service under the Medicare program.

Covered hospice services will be delivered and reimbursed at one of four levels, the utilization of which shall be determined by the hospice provider within the context of the overall utilization and

18. Hospice Care (continued)

reimbursement limitations contained in 405 IAC 5 and 405 IAC 1-16. The levels of care are:

(1) Routine home hospice care.
(2) Continuous home hospice care.
(3) Inpatient respite care.
(4) General inpatient hospice care.

When routine home care and continuous home care are furnished to a recipient who resides in a nursing facility, the nursing facility is considered the recipient's home. The usual home of the hospice recipient determines the location of care for that recipient. For purposes of the covered services rule, hospice location of care will be categorized according to one of two locations.

"Private home" location of care applies if the recipient usually lives in his or her private home.

"Nursing facility" location of care applies if the recipient usually lives in a nursing facility.

The additional room and board amount available for nursing facility residents under 405 IAC 1-16-4 is available only if the hospice recipient meets the criteria for nursing facility level of care under 405 IAC 1-3.

19. Targeted Case Management	Provided with limitations.
For Persons with HIV	Targeted case management services are limited to no more than sixty (60) hours per quarter.
For Pregnant Women	Provided with Limitations Targeted case management services are limitec to one initial assessment per pregnancy, one reassessment per trimester following the trimester in which the initial assessment is completed and one postpartum assessment per child born of the pregnancy. Mileage reimbursement is limited to a maximum of two round trips per initial assessment and reassessment completed and one round trip per postpartum assessment completed.
For Individuals identified as Seriously Mentally Ill or Seriously Emotionally Disturbed	Provided with Limitations Targeted case management services are limitec to those provided by or under the supervision, direction of a qualified mental health professional who is an employee of a provide agency approved by the Department of Menta Health under IC 16-16-1-1.
. Extended Services for Pregnant Women	Provided with limitations.
20.a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends	Legend and non-legend drugs, which are prescribed for indications directly related to th pregnancy, routine prenatal, delivery and post partum care, including family planning services. Additionally, transportation services, to and from the aforementioned services will be provided. Payment for pregnancy related services is subject to prio authorization in accordance with th guidelines set out in 405 IAC 1-6 and 1-7.
Additional services provided to pregnant women only.	Case management services as defined in, and tc the group specified in, Supplement 1 to Attachment 3.1-A. Limitations placed on the provision of these services are described unde #19 above.